Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PETER M SHEDDEN MD
9200 NEW TRAILS DR
THE WOODLANDS TX 77381

Respondent Name

TRAVELERS INDEMNITY CO OF CT

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-0369-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code was dropped. All other codes were paid. We have appealed this and then it was denied as duplicate appealed again denied timely filing."

Amount in Dispute: $7,800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider was properly reimbursed based on the terms of the contract between Carrier and the Provider through the Carrier's medical contract vendor, Aetna." "Additionally, the Provider failed to request Medical Dispute Resolution within one year of the date of service, 8/31/09. The request was not received by MDR until 10/4/11, over two years following the date of service; therefore, this request for MDR should be dismissed."

Response Submitted by: TRAVELERS, c/o David Klosterboer & Associates, 1501 S. Mopac Expressway, Suite A-320, Austin, Texas 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2009	63075	$7,800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 6, 2009
   - CSOR – 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. A COPY OF THE SURGICAL REPORT WILL BE NEEDED TO REVIEW THIS SERVICE.

   Explanation of benefits dated January 15, 2010
   - PO8N – W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. BASED ON ADDITIONAL INFORMATION RECEIVED FOR THE SERVICE/PROCEDURE. AN ADJUSTMENT HAS BEEN MADE TO THE TOTAL REIMBURSEMENT OF THE ORIGINAL INVOICE PER YOUR PPO CONTRACT.

   Explanation of benefits dated January 19, 2010
   - TR32 – 17 – PAYMENT ADJUSTED BECAUSE REQUESTED INFORMATION WAS NOT PROVIDED OR WAS INSUFF/INCOMPL. REVIEW OF SUBMITTED DOCUMENTATION DOES NOT SUBSTANTIATE BILLED SERVICE.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor waive their right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states in pertinent part that a request for medical fee dispute resolution shall be filed no later than one year after the date(s) of service in dispute or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. The date of service in dispute is August 31, 2009. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on October 4, 2011.
2. 28 Texas Administrative Code §133.307(c)(1) states that a request shall be timely filed with the Division's MDR Section or waive the right to medical dispute resolution. The Division finds that the requestor has failed to timely file this dispute with the Division's MDR Section and has therefore waived the right to medical dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 26, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.